(2) The State submits an actuarial report demonstrating that the modification does not reduce the actuarial value of the coverage under the program below the lower of either—

(i) The actuarial value of the coverage under the program as of August 5, 1997; or

(ii) The actuarial value of a benchmark benefit package as described in § 457.430 evaluated at the time the modification is requested.

### § 457.450 Secretary-approved coverage.

Secretary-approved coverage is health benefits coverage that, in the determination of the Secretary, provides appropriate coverage for the population of targeted low-income children covered under the program. Secretary-approved coverage, for which no actuarial analysis is required, may include, but is not limited to the following:

(a) Coverage that is the same as the coverage provided to children under the Medicaid State plan.

(b) Comprehensive coverage for children offered by the State under a Medicaid demonstration project approved by the Secretary under section 1115 of the Act.

(c) Coverage that either includes the full Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit or that the State has extended to the entire Medicaid population in the State.

(d) Coverage that includes benchmark health benefits coverage, as specified in § 457.420, plus any additional coverage.

(e) Coverage that is the same as the coverage provided under § 457.440.

(f) Coverage, including coverage under a group health plan purchased by the State, that the State demonstrates to be substantially equivalent to or greater than coverage under a benchmark health benefits plan, as specified in § 457.420, through use of a benefit-by-benefit comparison which demonstrates that coverage for each benefit meets or exceeds the corresponding coverage under the benchmark health benefits plan.

[66 FR 33823, June 25, 2001]

### § 457.470 Prohibited coverage.

A State is not required to provide health benefits coverage under the plan for an item or service for which payment is prohibited under title XXI even if any benchmark health benefits plan includes coverage for that item or service.

### § 457.475 Limitations on coverage: Abortions.

(a) *General rule.* FFP under title XXI is not available in expenditures for an abortion, or in expenditures for the purchase of health benefits coverage that includes coverage of abortion services unless the abortion services meet the conditions specified in paragraph (b) of this section.

(b) *Exceptions*—(1) *Life of mother.* FFP is available in expenditures for abortion services when a physician has found that the abortion is necessary to save the life of the mother.

(2) *Rape or incest.* FFP is available in expenditures for abortion services performed to terminate a pregnancy resulting from an act of rape or incest.

(c) *Partial Federal funding prohibited.* (1) FFP is not available to a State for any amount expended under the title XXI plan to assist in the purchase, in whole or in part, of health benefits coverage that includes coverage of abortions other than those specified in paragraph (b) of this section.

(2) If a State wishes to have managed care entities provide abortions in addition to those specified in paragraph (b) of this section, those abortions must be provided under a separate contract using non-Federal funds. A State may not set aside a portion of the capitated rate paid to a managed care entity to be paid with State-only funds, or append riders, attachments or addenda to existing contracts with managed care entities to separate the additional abortion services from the other services covered by the contract.

(3) Nothing in this section affects the expenditure by a State, locality, or private person or entity of State, local, or private funds (other than those expended under the State plan) for any abortion services or for health benefits coverage that includes coverage of abortion services.